ASSEMBLY BILL No. 1481

Introduced by Assembly Member Richman

February 22, 2005

An act to add Section 14087.306 to the Welfare and Institutions Code, relating to Medi–Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1481, as introduced, Richman. Medi–Cal: managed care.

Existing law provides for the Medi–Cal program, which is administered by the State Department of Health Services and under which qualified low–income persons receive health care services. Each county is responsible for eligibility determinations under the Medi–Cal program.

Under existing law, at the time of determining or redetermining the eligibility of a Medi–Cal applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, the county is required to ensure that each applicant or beneficiary personally attends a presentation at which the applicant or beneficiary is informed of the managed care and fee–for–service options available regarding methods of receiving Medi–Cal benefits. These health care options include the continuation of an established patient–provider relationship in the fee–for–services sector, the continuation of an established patient–provider relationship in a managed care option under prescribed circumstances, or in areas specified by the director, if the applicant or beneficiary fails to make a choice or does not certify that he or she has an established relationship with a primary care provider or clinic, the applicant or beneficiary shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot projects, or fee–for–service case management provider.

Under existing law, in areas specified by the director, no later than 30 days following the date a Medi–Cal beneficiary or applicant is determined eligible for Medi–Cal, the beneficiary is required to indicate his or her choice, in writing, from among the available prepaid health plans contracting to provide Medi–Cal services in the region.

Existing law provides for a comprehensive program of managed health care plan services to Medi–Cal recipients residing in clearly defined geographical areas. Existing law provides that enrollment in this program is voluntary for beneficiaries eligible for Medicare.

This bill would provide that notwithstanding any other law, commencing July 1, 2008, enrollment in either a Medi–Cal managed health care plan or a managed health care plan in a defined geographical area shall be mandatory for Medi–Cal beneficiaries, with specified exceptions, who are also eligible for, but need not be enrolled in, the Medicare program.

This bill would require the department to seek a federal waiver that will provide federal financial participation for a dual eligible, defined as a Medi–Cal beneficiary enrolled in the Medicare program, who is enrolled in Medi–Cal managed care and to seek any other federal waivers necessary to implement the bill. The bill would provide that it shall only be implemented if, and to the extent that, these waivers are obtained.

The bill would impose various duties on the department in implementing the bill, including providing to the appropriate committees of the Legislature information regarding the department's plans to implement the mandatory enrollment of dual eligibles into managed care, consulting with various stakeholders and other parties with an interest in health care for aged, blind, and disabled persons, undertaking an independent assessment of the encounter data collection process in the Medi–Cal managed care system, developing and implementing a corrective action plan, and reporting information related to the data to the Legislature, and performing activities related to quality of care measures for Medi–Cal beneficiaries subject to these provisions.

The bill would establish requirements for health plans that contract to provide Medi–Cal managed care services to Medi–Cal beneficiaries who are subject to these provisions.

This bill would require the department to implement the provisions of this bill only if it obtains the necessary agreement from the federal

government to continue to receive disproportionate share hospital payments in proportion to the patients transferred to managed care as a result of existing statutory authorization for the department to contract with any qualified individual, organization, or entity to provide services to, arrange for or case manage, the care of Medi-Cal beneficiaries.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Aged, blind, and disabled persons enrolled in the Medi–Cal program stand to benefit from improved health care that can come from a shift from a fee–for–service delivery system to managed care.

(b) Managed care has proven to offer some significant advantages over a fee–for–service delivery system in regard to case management, coordination of patient care, quality and access to care, and containment of program costs.

(c) Managed care plans that contract with the Medi–Cal program undergo annual quality reviews to measure health plan performance in regard to the quality of services provided to Medi–Cal beneficiaries. In contrast, the quality of care delivered to Medi–Cal patients by fee–for–service health care providers is not measured in this manner by the State Department of Health Services.

(d) A shift to managed care is likely to result in annual and ongoing long–term savings to the state because preventative care might reduce the future use of health care services.

(e) Improvements in the Medi–Cal managed care system could better enable the State Department of Health Services to ensure access to services and quality of care for aged, blind, and disabled beneficiaries.

SEC. 2. Section 14087.306 is added to the Welfare and Institutions Code, to read:

14087.306. (a) For the purposes of this section, the following definitions shall apply:

(1) "Dual eligible" means a Medi–Cal recipient who is also enrolled in Medicare (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)).

(2) "Long–term care services" means services provided to the elderly and people with disabilities who need care due to chronic conditions including, but not limited to, medical care, therapy, rehabilitation, case management, nursing home care, protective supervision, and assistance in daily activities, such as bathing and eating.

(3) "Share of cost" means the amount of health care expenses a recipient must accumulate each month before Medi–Cal begins to offer assistance.

(b) (1) Notwithstanding any other provision of law and except as provided under paragraphs (2) and (3), commencing July 1, 2008, enrollment in either a Medi–Cal managed health care plan as provided under Section 14087.305 or a managed health care plan under Article 2.91 (commencing with Section 14089) shall be mandatory for any Medi–Cal beneficiary who is also eligible for, but need not be enrolled in, Medicare.

(2) Paragraph (1) shall only apply to dual eligibles enrolled in Medi–Cal managed care and to any other Medi–Cal beneficiaries, if and to the extent that, federal waivers required pursuant to subdivision (c) are obtained.

(3) This section shall not require any of the following persons to enroll in a managed care delivery system:

(A) Persons eligible for the California Children's Services program.

(B) Persons eligible for long–term care services under Article 4.3 (commencing with Section 14139.05).

(C) Persons eligible for Medi–Cal with a share of cost.

(c) (1) The department shall seek a federal waiver that provides federal financial participation for a dual eligible enrolled in Medi–Cal managed care. If a waiver is obtained, the department shall provide to the appropriate fiscal and policy committees of the Legislature, within three months of this approval, information regarding the department's plans to implement, as required under this section, the mandatory enrollment of dual eligibles into managed care.

(2) The department shall seek any other waivers necessary to allow federal financial participation under this section.

(d) On or before July 1, 2007, the department shall consult with health plans, direct medical care providers, Medi–Cal beneficiaries, health advocacy groups, and other parties with an interest in health care for aged, blind, and disabled persons. These consultations shall address, but not be limited to, technical issues related to the mandatory enrollment of additional aged, blind, and disabled Medi–Cal beneficiaries into Medi–Cal managed care, and issues raised by stakeholders. This subdivision shall not be interpreted to limit the scope of discussion between the department and stakeholders.

(e) On or before July 1, 2007, the department shall provide information on the best practices for managing the care of aged, blind, and disabled persons to health care plans with whom it intends to contract, or has a contract, for the provision of these services. The information provided may be limited to best practices developed by managed care plans that contract with Medi–Cal, based on their experience in providing care to aged, blind, and disabled persons.

(f) The department shall undertake an independent assessment of the encounter data collection process in the Medi–Cal managed care system and develop and implement a corrective action plan. The department shall report to the Legislature on or before January 1, 2007, on all of the following:

(1) The completeness of the data.

(2) The accuracy of the data.

(3) How the data will be used by the department.

(g) Beneficiaries subject to this section shall be provided all options and materials available under the health care options process as prescribed in Sections 14016.5 and 14087.305.

(h) The department shall utilize the same process described in Section 14087.305 to inform all Medi–Cal beneficiaries subject to this section of their choices of participating plans and allow a beneficiary to choose or change his or her participating plan.

(i) The department shall require all health plans that contract to provide Medi–Cal managed care services to Medi–Cal beneficiaries who are subject to this section to conduct a health assessment to determine the health care needs for that population of Medi–Cal beneficiaries.

(j) The department shall ensure that the quality of care for the population of Medi–Cal beneficiaries subject to this section is

measured. Where independent groups have not developed standard sets for the purpose of measuring performance that are pertinent to this population, the department shall develop those quality of care measures and require health plans providing services to those Medi–Cal beneficiaries to report to the department annually their performance in regard to these quality of care indicators. This section shall not be interpreted to limit the scope of any assessments that would otherwise be performed by the department.

(k) This section shall not require that any of the following services be incorporated into any expansion of the managed care delivery system provided under this section:

(1) Mental health care services provided by county mental health systems of care.

(2) Alcohol and drug treatment services.

(3) Adult day health care services.

(4) Dental services.

(*l*) This section shall not be interpreted to limit the department from making the decision to exclude additional services from the Medi–Cal managed care delivery system. It is not the intent of the Legislature to preclude future restructuring of these programs by the department.

(m) The department shall implement this section only if it obtains the necessary agreement from the federal government to continue to receive disproportionate share hospital payments in proportion to the patients transferred to managed care as a result of this article.

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